



Date: June 3, 2011

To: Administrator Miller and
members of the NAIC Consumer Information working group

From: Lynn Quincy, Consumers Union
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Subject: Preliminary Findings from Consumer Testing the Coverage Facts Label

Disclaimer: The analysis in this memo is to be considered preliminary. A complete analysis with detailed findings will be available on approximately June 30th.

STUDY APPROACH

This study used cognitive interviewing and usability testing to observe consumer understanding of the Coverage Facts Label (CFL) —which is called Examples of Plan Coverage in the test documents.

Cognitive interviewing is a one-on-one technique that uses small numbers of participants to explore how consumers make sense of the information within a document or web site. Despite a small number of participants, this technique yields rich and nuanced data because the consumers' actions can be precisely observed and their responses explored in a consistent manner. At the same time, the one-on-one approach allows the moderator the flexibility to explore individual responses in-depth. Researchers often cannot capture the thinking process of a participant as he or she answers a survey question or participates in a focus group. Cognitive interviewing allows the researcher to elicit from an individual the thinking behind the answers, providing researchers with a more detailed understanding that is critical to improving consumer documents.

For this study, we conducted 16 one-on-one interviews (each lasting 90 minutes) in two sites: St. Louis, MO and Buffalo, NY. Our participants were recruited from two groups—uninsured and self-pay (non-group coverage). We interviewed an equal number of men and women, and a range of ages and educational levels. Based on our observations, these consumers had a wide range of familiarity with health insurance concepts, ranging from quite expert to completely unfamiliar with terms like “deductible,” “coinsurance,” and “benefit limits.”

In the first part of the session, participants were asked to “think aloud” while they shopped for a health plan using the test documents. Participants could look at the 6-page form in any order, skipping around if they wished, and their reactions observed. In the second part of session, they were prompted to examine pages 5 and 6 (the CFL) more closely and a series of question was asked about how they viewed different aspects of the form, as well as the thinking behind how they selected their plan. We alternated which Plan and which CFL version was presented first.¹ The testing questions and scenarios were designed to assess consumers’ understanding by using an approach that mirrors real world shopping for coverage as closely as possible. The goal was to gain insights about how to design the CFL to best aid consumers in selecting the best health plan for their needs.

STUDY FUNDING

Missouri Health Foundation, New York State Health Foundation, and Consumers Union provided funding for this study.

OVERALL FINDING

When consumers shop for health coverage, they overwhelmingly desire a “bottom line” number that tells them how much the plan will pay for health services in exchange for their monthly premium payment. Participants in this study understand that higher premiums will result in more coverage and lower premiums will result in less coverage. Many refer to this as shopping for the “best value” plan; they want to find the sweet spot between coverage of the health care they need, balanced against the premium they can afford. Yet, multiple information gaps interfere with making this best-value assessment:

- uncertainty about their future health,
- lack of knowledge of treatment steps,
- the cost of treatment steps, and
- their share of the treatment costs after the plan pays.

The CFL cannot help consumers assess their future health care needs and use. Consumers must assess their future health care use based on their own perception of their health and their tolerance for risk. The CFL, however, will help consumers assess the other three of these four unknowns. In this study, participants found it eye-opening to see the treatment steps, the overall costs for the treatment steps, and their share of those costs.

¹ Version 1 presented the three examples showing detailed costs. Version 2 presented the three examples showing rolled up costs. Both versions had different information on page 6. The testing documents are available on the NAIC website. http://www.naic.org/committees_b_consumer_information.htm The complete methodology will be included in the final report.

As such, the CFL fills a critical need. It allows consumers to see how the abstract information in the Summary of Coverage form works in a concrete example. The CFL information provides a completely different and valuable way for consumers to assess health plan offerings (compared to considering just the enrollee's cost for the premium and the deductible). In addition, the participants in this study readily understood that the CFL was an estimate, and not a precise amount that the plan would pay for them. Finally, the CFL enhanced their understanding of pages 1-4 of the Summary of Coverage form.

DETAILED FINDINGS

For the detailed discussion, we address Page 5 and Page 6 separately.

PAGE 5, OVERALL

Participants reported that the CFL (p. 5) was helpful in comparing health plans, with Version 1 (the detailed version) preferred by almost all. While participants did not go so far as to state that they needed Page 5 to select a plan, their responses to Page 5 (particularly Version 1), suggests that this page is very valuable.

The CFL provided a concrete anchor for the benefits of the plan. Even when their share of costs using information on pages 1-4 was confusing or abstract, the information on page 5 was fairly straightforward and accessible to them.

[On the first four pages] there isn't anything concrete that I can understand exactly what it's going to be to me, what my fair share is going to be . . . [on page 5] it doesn't have to be relevant to you, it gives you a good example." Buffalo 6

As such, the information on page 5 provided more confidence that they could understand the general scope of what the health plan was going to pay.

The CFL made it clearer why health coverage is important. After seeing the overall cost of treatment, participants noted that the importance of having coverage was clearer since the cost of a major illness could be financially ruinous.

Wow! Treating breast cancer--\$98,000. That's pretty crazy. I never really thought about that. I have known a couple friends of the family that have had breast cancer and I can't imagine going through that and having to pay \$98,000. That's definitely pretty awesome that they would pay \$94,000 of that. St. Louis 6

The CFL gave participants a more positive view of the health plans. Participants perceived the information on pages 1-4 as costs they have to pay and were sometime suspicious of the health plan, wondering why there was a premium and then a deductible and then deductible for pharmacy costs and then co-pays and many other things that did not count toward the deductible.

Well, if I was going to get health insurance, I would want a health insurance that's going to provide health insurance for me [and] that's also going to pay.... When I go to the doctor, I'm going to pay \$10, \$20 for every time that I go. [It's] not I get paid my entire doctor bill up until \$5,000, before I'm just paying \$10, \$20 every time I go to the doctor.
Buffalo 6

Many participants developed a more favorable impression of the coverage after seeing page 5. They felt better about deductibles of \$2,500 and \$5,000 when they saw what they *weren't* paying and also felt better about the premium costs.

I would probably choose the \$481 [monthly payment] because like I said it's easy to pay a smaller amount than "today's Tuesday and now I got to have \$5,000 by Wednesday." So it's a big difference in trying to pay \$2,500 so yeah, I think I would probably rather pay a couple dollars more so when I do get hit, I'll pay less. . . . Buffalo 4.

[In looking at pages 1-4] \$5,000 deductible. Forget that. ... That's too high. ...there better not be a co-pay if they want \$5,000 deductible. ... [In looking at page 5] I look at [this deductible] \$5,000, that's ridiculous. But then when you think [breast cancer] may cost you \$98,000. St. Louis 7

The CFL helped clarify the coverage of maternity. Some (but not all) participants understood from pages 1-4 when maternity was *not* covered, but all figured it out by the time they reviewed page 5. On the other hand, participants had great difficulty assessing when maternity was covered using pages 1-4. (In point of fact, participants could only assess this by the absence of an exclusion—an incredibly difficult cognitive task and about which they were appropriately insecure about whether they had assessed correctly.) Page 5 provided the confirmation that they needed. In addition, it provided an indication of what their share of the cost would be—something impossible to figure out from pages 1-4.²

. . . and then my plan pays zero so that means if you pay zero to the provider and then I pay \$10,000. . . . So that policy doesn't cover having babies. This one does...they cover this 90%. Buffalo 8

Participants tended to look at the information in tables before looking at the additional information on the page. Participants, in general, looked at the table presentation on both versions of the CFL before they read the text above and to the left. Their natural inclination was to scan this prose information rather than to "read" it. Part of this attention to the table occurred because the previous four pages used tables to hold key information and they had "learned" that important information was placed in tables. In addition, research shows that

² Maternity costs reflected that fact that the plan paid a global fee to providers, so enrollees just pay for their initial office visit, copayments for two ultrasounds, and their share of hospital costs. It isn't possible to know this based on pages 1-3.

participants typically look at graphical presentations of information before even noticing information presented as prose.

Consumers liked the detail of the examples in Version 1. Most consumers liked having the detail in Version 1 because it gave them a sense of what their costs might be.

You'd want to know if I was having such and such done what is going to be covered and what is not going to be covered, It's not exact but it's still going to be close. Buffalo 6

I like this. The lump sum one doesn't do you any good. St. Louis 7

PAGE 5, COVERAGE EXAMPLES

The three coverage examples—having a baby, treating breast cancer, and managing diabetes – provided worked well for participants.

Participants believed the three examples were “logical.” With a few exceptions, participants liked the examples and felt they “made sense.” It seemed to them that an appropriate variety had been provided, even though not all of the examples were relevant to them. They noted that the examples were “common” events, such as having a baby, and included both a catastrophic illness and a chronic illness.

It's a broad spectrum, it's three completely different things, kind of break it down what each one entails as well, completely different things as far as treatments and stuff like that. ... I'm going to guess that's three things that are huge in the nation. I think breast cancer is a big thing. Obviously diabetes is a big thing and maternity may be the biggest thing. To me that's why they use three examples because it's three things that are...some things that are important things. People are dealing with daily and things of that nature. Buffalo 4

Maternity is an event, breast cancer is some sort of cancer, so ongoing treatment and this is like a maintenance of an existing condition, this is like something that someone has to deal with for the rest of their life. St. Louis 4

Even when they noted that the examples were not relevant to their health situation, most found the three medical scenarios to be useful in assessing a health plan. Some noted that the examples would help others, others thought that these could be scenarios that happen to them in the future, and some noted that it still provided them with a useful sense of what the plan would pay for them in a different but similarly costly medical situation. Some wondered why maternity was included in the plan that didn't cover maternity. In part, they didn't understand that the “having a baby” example is required by law. In addition, it's is possible that participants were more negative about this example because this example was the hardest to understand.

Participants suggested some alternative examples of coverage, but the category logic remained the same. Some participants wanted an example that would be more relevant to

them than maternity coverage. When asked what alternative example would help them, participants recommended continuing to select a single example from various “categories” of health events. In terms of a common and somewhat routine event, they suggested a visit to the emergency room, for example for a child’s broken bone, or a checkup or a colonoscopy. For catastrophic events, they suggested heart disease or a stroke or cancer in general, rather than breast cancer.

PAGE 5, CONSUMER WARNINGS

Almost all participants understood that the examples did not give a precise estimate of their own costs if they were to need one of these three health services or if they needed a similar health service. Participants derived this information based on their own previous experience with health care/health insurance or their own reasoning skills when they saw the list of “sample care costs” in Version 1.

The number of warnings undermined the credibility of the plan providing the information.

Participants often reacted negatively to the overuse of “might” and the number of warnings. More than one participant commented on the ways the plan gives information, suggesting that coverage exists and then uses a warning to suggest that the information is not quite accurate. The page subtitle uses “How this health plan might cover health care costs.” In Version 1, the first column includes “might cover” and “protection you might get.” In addition, the first two paragraphs tell the reader how to use the examples and the information under “Important” then tells the reader how **not** to use the examples. Some participants concluded that this text then represented the plan covering itself and not protecting the consumer. When consumers skipped this information and focused on the tables themselves, they saw the information as helpful and creating a more favorable impression of the health plan.

PAGE 5, FEW RECONCILED “YOU PAY” DETAIL WITH PLAN’S COST SHARING PROVISIONS.

We rarely observed participants trying to reconcile the CFL “you might pay” detail back to the plans’ underlying cost-sharing provisions. Most calculated the rough share paid by the plan, were satisfied with the result, and did no additional calculations. For some, this approach may reflect the extreme difficulty they had understanding the information on pages 1-3.

A minority of participants did try to reconcile some of the detail in the Version 1 “you might pay” column back to the earlier information. When they could anchor it (like the deductible amount for breast cancer), they gained confidence in their assessment of the plan. For the remaining provisions, which couldn’t be reconciled back, we observed two responses: most assumed that this was just due to their incomplete understanding of the information on pages

1-3. They simply assumed it was “beyond them.” Those with a better understanding of health plan cost-sharing, but couldn’t perform this exercise, were mildly frustrated.

This experience also serves to demonstrate another value of the CFL. The information in page 5 of the CFL not only complements but *supplements* the information on pages 1-4 of the form. Put another way, the detail on pages 1-4 is insufficient to provide a clear sense of patient costs in many situations. For example:

- In Plan 1, maternity is paid based on a global fee to the provider that includes all prenatal care, delivery and post-natal care. The member only pays for the initial office visit when the pregnancy diagnosis was made (despite the fact that treatment includes multiple office visits), copayments for two ultrasounds, and their share of the hospital fee.
- In Plans 1 and 2, routine eye exams are not covered. Yet these exams were covered for the diabetic scenario because it was a service provided during a normal office visit (Version 2 of the CFL lists eye exams as covered, although that detail wasn’t present in Version 1).
- In Plan 2, specialty drugs (including chemotherapy) are subject to 50% coinsurance according to page 3. However, because chemotherapy is not self-administered, these drugs are not subject to the pharmacy deductible but to the medical deductible. (Chemotherapy drugs are administered in the doctor’s office.) In the example, the medical deductible was reached once the surgery was complete. The patients OOP limit was also reached (being identical to the medical deductible), so the coinsurance on the chemotherapy drugs was effectively zero.

PAGE 5, WHY PARTICIPANTS COULD NOT USE VERSION 2 AS WELL AS VERSION 1.

A few participants preferred Version 2. These participants skimmed the listed services and were interested only in the “Patient Might Pay” information. They found the details of Version 1 confusing and uninteresting. However, these participants were in a minority. Generally, Version 1 was preferred over Version 2 for the following reasons.

The phrase “Allowed Amount” is confusing and off-putting. In Version 2, participants struggled to understand what “Allowed Amount” meant. To some, it referred to the amount that out-of-network providers would be able to collect or be able to charge. Some were unclear if this was an annual benefit limit. Even if they returned to page 2 of the form, they could not find the definition of “allowed amount.”

And just going down here the plans payment for covered services based on the allowed amount, that is unclear about what the allowed amount is because it was just saying basically it is going to pay for everything, you have a deductible and then it will pay for

everything after that, so what exactly is the allowed amount if it is paying for everything? St. Louis 5

In Version 2, most participants did not calculate what the plan paid. While participants understood the amount of “Allowed Amount” and could see what the “Patient might pay,” they did not comment on the amount that the plan paid. With Version 1, participants commented on how much the plan was paying for breast care treatment or of the maternity benefits. Making that information explicit as in Version 1 helped participants understand the benefit they received from having health care coverage.

[Version 1] showed me how much money I’m saving or it couldn’t be . . . I couldn’t treat breast cancer if I don’t have insurance because I would have to come up with \$98,000. Buffalo 8.

In Version 2, participants lost the opportunity to see how their personal situation might affect costs. When participants have the details, they were able to determine how costs could change. For example, one participant commented on how she might not need anesthesia for maternity and so her costs could be lower (St. Louis 3). In addition, without details, participants seemed to question the reliability of the rolled up number. They were unsure if they could trust the number because they simply didn’t know what the Allowed Amount represented and where it was coming from.

Where are you getting this \$10,000.00 number from? What hospital charges \$4,100.00 for the mother? Is that in New York City or is that in the sticks? What is this based on? St. Louis 5

PAGE 6

Participants were reluctant to read page 6. Both the layout and the content were off-putting to nearly all participants.

The layout of page 6 used virtually no graphical elements. Participants were put off by the change from the five highly formatted pages that relied on tables rather than prose to convey information. Many commented that page 6 looked like too much to read and was too dense (“too wordy”). To some extent, they assumed that this information was not important because it had no “special” treatment and so there was little reason to read it.

Participants preferred the Q&A format of Version 2 to the prose presentation of Version 1. Participants were able to skim the Q&A format better than the other version. However, their opinion of the layout remained the same. They did not find this inviting to read and thought the questions, and especially the answers, repetitive.

Participants found the contents of page 6 in Version 1 and Version 2 uninformative. The few participants who read page 6 on their own thought it added no information or stated the obvious. Even when prompted to look at it, participants did not say that it was useful. One

participant said there was no “ah ha” information on the page. For example, after reading “Choosing a Plan” on Version 1, participants felt it had told them what they already knew. However, some liked having their process reinforced by the bulleted list.

The Bottom line: participants felt that they had to expend too much effort to read for too little return in terms of information.

RECOMMENDATIONS FOR PAGE 5

Based on participants’ statements and our observation of their reactions, our preliminary recommendations are as follows:

- 1. Use Version 1.** The remaining recommendations apply to Version 1, page 5.
- 2. Test a new title for this page and then use consistent language to refer to the [Consumer Facts Label] within the document.** The two pages are never referred to as a CFL within this text. Instead it is labeled “Examples of Plan Coverage” and “Coverage Examples.” It also has a subtitle of “How this Plan Might Cover Health Care Costs” with references to the Plan Summary. All of this variation creates a dissonance for the reader and a lack of clarity. Instead of “Examples of Plan Coverage,” consider testing “Coverage Examples” or “Sample Costs for Three Medical Scenarios” to see if these titles help consumers better understand the purpose of the information.
- 3. Put more emphasis on the new title of this page.** Currently, the emphasis is placed on the “PPO Plan X: Insurance Company X.” The “Examples of Plan Coverage” is subordinated to the Insurance company name. We recommend reversing this emphasis on all pages. It's important to consider the way that consumers will most likely navigate and refer to these pieces of information.
- 4. Reduce the warnings.** Let the new title carry the bulk of this duty. Remove much of the text from Column 1 and replace with the answer to the question on page 6 of Version 2: “What are coverage examples and what are they in this summary?” Or consider text something like this:

“Your own health care needs may be different, but here are three examples of health situations that many people encounter:

 - having a baby
 - having a major illness
 - having a chronic illness

These examples show, in general, how much insurance protection you could get from this plan. Other plans could give you different coverage. You should compare.”
- 5. Fine tune and test the presentation within the three examples.** Although these examples work very well, some additional fine tuning will make them more powerful.

- First, put more emphasis on the three key pieces of information above the Sample care costs. In the current design, it is difficult to “quickly” see how the three pieces of information fit together. Putting equal emphasis on the three terms “amount owed to providers”, “Plan pays” and “You pay” could help.
- Avoid the use of “might” in the section “You might pay.” “Might” was highly distracting for about half of the participants, and seemed to do little to increase understanding of the estimate. To avoid the repetition of “You pay,” consider a phrase like “Your payment comes from.”
- Don’t use current shading in the bullets on plan pay/you pay lines. Participants tried to link these to the shaded rows down below (ie, perhaps you just add up all the light blue rows in the table). Make these a uniform color that is not the same as the row shading.
- Consider adding an additional example. Although these three examples worked very well, consumers were interested in some additional details. If space is not available, these examples could be available online.

6. Use a different approach than the asterisk approach to convey information on the costs of not-covered-maternity coverage. The asterisk approach was hard for participants to decipher. Instead, consider adding text like this when the service is not covered:

- Amount owed to providers: \$10,000
- Plan Pays: \$0
- You Pay: \$10,000 (because maternity is not covered out-of-network rates apply, which could be higher than shown here)

7. Delete the “questions” in the left column. It duplicates the information in the footer and participants seemed to easily grasp that they could call the health plan with their questions. In addition, most participants said that they would “google” any term that they did not understand.

RECOMMENDATIONS FOR PAGE 6

8. Omit most of the current information. If consumers don’t read it, then it is real estate that could be put to better use. Including information that consumers consider repetitive or uninformative undercuts the positive attitudes created by the information on page 5.

9. Include a less wordy version of “Choosing a health plan” in the left column. While most participants felt the content was self-evident, they also found the information in the checklist to be reassuring.

10. Use the rest of the page for definitions. Because most participants did not see the definitions on page 2, it seems useful to consider including a short glossary of terms that were confusing to consumers. The key phrases seem to be:

- Deductible, clarifying that some services are subject to the deductible.
- Coinsurance (move from page 2 where they are still overlooking in). Make it completely obvious that 20% is an example. When this was located on page 2, a few participants believed that the plan they were looking at paid 20%.
- Allowed amount. See earlier discussion.
- Out of pocket limit.

11. Consider this alternative sample to page 6. At the end of this document, we’ve included a sample of what page 6 could be like if recommendations 9 and 10 are used. Compared to the varying approach to definitions on pages 1 and 2, these definitions are grouped together and ordered in a sequence that might be useful to consumers.

12. Test any changes. Changes are hypotheses that we have put together information in an appropriate and useful way for consumers. Testing allows us to decide based on consumer input which hypotheses are correct and which need further refinement.

FINAL OBSERVATIONS

One additional comment: on page 4, the line directing participants to page 5 is not needed. It was noticed by only one participant.

The results of this round of testing are remarkably positive. Participants responded well to the CFL information. And the information helped consumers reach a higher level of understanding. As one participant put it,

... it's kind of like going into a house when you're buying a house. You want to imagine what is going to be in that house and what kind of furniture you're going to have. Where this [Version 1] gives you that imagination of what you could be using the plan for, what you could be spending this money for—and on, and how much money you'd be spending.
St. Louis, 3

That said, it's important to put these results in the context of a larger formative and development process.

While many consumers have previously encountered the core elements of pages 1-4, the information on page 5 is brand new to them. As such, this study captures their initial reactions when they effectively have a “blank slate.” However, consumers’ response to the CFL (as well as

the overall form) will evolve once the form becomes more common. This round of testing (as well as other studies) show that consumers rely heavily on prior experience with insurance to interpret health plan information. As such, we should reexamine how well the consumer facts label is working once it goes into widespread use.

Introduction of a new process or new information is challenging and risky for both consumers and the health plans. Consumers are at risk of not understanding the information and therefore thinking it irrelevant or not useful. Health plans are at risk because consumers could misunderstand or misinterpret the materials and draw false conclusions about the health plans' motivation in providing the information.

Consumer testing helps refine researchers' understanding and ensure that the document works for the intended audience. But its real strength is its ability to reduce risk to the health plans. Although we know that consumers learn over time how to use standardized presentations, testing allows us to reduce the risk to consumers and to health plans. The more intuitive the material for consumers, the more the misunderstandings that are often inherent in initial versions of materials can be erased or eased, the more the reduction of risk. The goal of these materials is to do no harm.

This round of testing identified many of the strengths of the two approaches and was able to show based on participants' performance that one design was superior to another. In addition, the changes recommended should further enhance the understanding and usability of the document for consumers. Additional rounds of testing will enable further refinements of language and presentation and further provide insurance that the document will work in positive ways for consumers and for the health plans.

FURTHER QUESTIONS

Contact Lynn Quincy, Senior Policy Analyst, Consumers Union at 202.462.6262.

PPO Plan 2: Insurance Company 2

Choosing a Plan	Definition of Terms		
<p>You want a plan that gives you the coverage you need at a cost you can afford. When comparing plans, look at:</p> <ul style="list-style-type: none"> ✓ Which services are covered and which are excluded (pages 2-4) ✓ Your share of the cost for covered services (pages 1-5) ✓ Premium – your [monthly] cost for this coverage. ✓ Other costs, such as contributions you make to Health Savings Accounts or Flexible Spending Accounts. ✓ Other benefits, such as contributions your employer makes to health savings accounts or Health Reimbursement Accounts to help you pay out-of-pocket expenses. <p>Before choosing, consult the definitions or call the plan to be sure you understand the provisions that affect your costs.</p>	<p>Co-payments or copays are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Services paid this way aren't usually subject to the deductible.</p> <p>When a service is subject to a deductible, you must pay all the costs up to the deductible amount before the health insurance plan begins to pay for covered services.</p> <p>Once you met your deductible, co-insurance is <i>your</i> share of the cost of these covered services.</p> <p>_____</p> <p>EXAMPLE: If the allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200.</p> <p>_____</p>	<p>The plan's payment for covered services is based on the allowed amount. This is an amount that the plan and their in-network providers have agreed to limit the charge to.</p> <p>If you use an out-of-network provider, they may charge more than the allowed amount and you may have to pay more as a result.</p> <p>_____</p> <p>EXAMPLE: If an out-of-network hospital charges \$1,500 for an overnight stay but the allowed amount is \$1,000, you may have to pay the \$500 difference, <i>in addition to</i> the normal coinsurance amount. (This is called balance billed charges.)</p> <p>_____</p>	<p>Many of your costs for using in-network providers are capped by the out of pocket limit -- the most you pay during a policy period (usually a year). Note: this limit never includes your premium, balance-billed charges or health care your health plan doesn't cover. Some health insurance plans exclude some of your other payments from this limit (see page 1).</p> <p>You may also have to pay the full cost of services that exceed the plan's annual limit.</p> <p>_____</p> <p>EXAMPLE: The plan limits coverage of outpatient mental health to 8 visits. You have to pay the full costs of visits 9 and above.</p> <p>_____</p> <p>You can find more definitions at www.insuranceterms.com</p>

Questions: Call 1-800.....